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Counseling Individuals and their Caregivers that have suffered a Stroke: A Clinicians Guide

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Counseling Individuals and their Caregivers that have suffered a Stroke: A Clinicians Guide

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Abstract

Counseling Individuals and their Caregivers that have suffered a Stroke: A Clinicians Guide

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This report was developed to help guide clinicians in using safe and effective counseling strategies when working with individuals that have suffered a stroke. Many individuals that have suffered a stroke have life altering deficits that impact not only themselves, but their family members as well. It is important that speech and language pathologists (SLP's) understand the impact that these family members face as well as the psychological disorders that an individual may face after having suffered a stroke. There are many psychological theories that SLP's can incorporate into their practice when working with this population as well as effective tools to help better facilitate the recovery process. The therapeutic process can have a greater impact when there is a positive rapport between the clinician and the individual, therefore, clinicians should encompass these therapeutic tools and strategies to help facilitate a more positive recovery for individuals and their family members.

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Introduction

Individuals that have suffered a stroke are often left with deficits that have become life altering not only for themselves, but for their loved ones. A stroke can cause physical as well as communication deficits. This in turn can leave family members lost and having to switch roles as primary caregiver. Speech and Language Pathologists (SLP's) are often faced with the obstacle of being a form of support for these individuals and families that are going through such difficult times. The purpose of this report is to help guide clinicians in how to best counsel families who have suffered a stroke. There are many tools and strategies that SLP's are able to use to be effective communicators and counselors for these individuals and their families. There are also psychological theories that SLP's may incorporate into their practice as a way of guiding themselves on effective forms of counseling.

Aphasia is a condition that affects all aspects of communication and is the result of brain damage. Quite often, the cause of this brain damage is a stroke. Language impairments that are associated with aphasia can include deficits in expression and understanding of written and spoken language. There are several types of aphasia that reflect different sites of injury and vary in severity. Traditional therapy for individuals with aphasia includes improving their skills enough to enable them to meet the functional cognitive-linguistic demands of basic daily living. Each individual is different with deficits varying in different areas, but most therapy will focus on improving a person's skills enough to enable them to meet their functional cognitive-linguistic demands of basic daily living. The most important and challenging goals in aphasia therapy is aiding

these individuals to re-enter society and improve their quality of life. Approximately 30% of first-time ischemic strokes result in some form of aphasia (Cranfield & Lalor, 2004). As the population within our country grows, the incidence of a stroke is only going to increase.

Counseling is a domain that is within the scope of practice for SLP's. An SLP may provide counseling by educating, guiding, and supporting individuals and their family members or caregivers (DeRuiter, et al., 2017). The SLP's counseling will include interactions related to emotional reactions, thoughts, feelings, and behaviors that result from living with a communication disorder (DeRuiter, et al., 2017). Counseling is necessary to support decisions and behaviors that optimize quality of life and offers the opportunity for an optimal outcome for clients.

The role of an SLP is complex. Treatment goals for individuals with communication disorders are to minimize the disorder's effects, but also to counsel involved persons to live productively and successfully with communication problems, or despite them, or around them (Holland & Nelson, 2014). Most communication problems have unique, significant, and reverberating effects on families, who are as likely to be as unprepared for these effects as those who have the communication impairments. The goal of the counseling process is to help individuals and families to live as successfully as they possibly can, despite intrusion of a catastrophic event such as a stroke that results in communication disorders (Holland & Nelson, 2014).

The counseling that is core to speech-language pathology is educational and rehabilitation counseling (Flasher & Fogle, 2004). A clinician's intention is to assist a

person or family member to understand the disorder that the individual is suffering from and ways of preventing, managing, adjusting to, or coping with it. Riley (2002) says that the goal of counseling is to facilitate individuals to find their own answers, experience an internal sense of control, and leave with new perspectives and the confidence that they continue to care for themselves. She lists several outcomes expected from counseling with a speech and language pathologist:

1. The client will be more self-aware and able to observe him- or herself with some objectivity.
2. The client will exhibit reduced limitations that inhibit choices.
3. The client will experience increased internal (vs. external) control.
4. The client will be able to recognize and accept responsibility for his or her feelings.
5. The client will demonstrate an increased use of "I" statements rather than "you" statements.
6. The client will be able to deal with uncertainty with less anxiety.
7. The client will have a more positive view of self and others.
8. The client will have made a commitment to continue to grow.

Crowe (1997) also identifies seven purposes of counseling for speech and language pathologists (p.105):

1. Gather and convey information (i.e. interviewing and presenting diagnostic information).
2. Prevent disorders from developing or from becoming more severe and involved.

3. Help clients adjust emotionally to their disorders and to resist developing counterproductive behaviors in reactions to them.
4. Help be supportive of families and significant others in coping with a client's disorder or disability.
5. Help clients improve their overall function and independence by learning decision-making and problem-solving skills, and maintain high motivation levels for therapy.
6. Provide an environment for clients that is optimal for change and improvement.
7. Help clients develop the self-reinforcement behaviors and coping strategies that are critical to successful carryover and generalization of therapy results.

Every aspect of an SLPs role as a diagnostician and clinician includes counseling as an integral part of interactions with clients and their families. A clinician has the ability to enter the individual's world and develop a therapeutic relationship (Flasher & Fogle, 2004). An individual's subjective experiences of communication problems are inevitably effected by the quality of the relationship with the clinician. An individual who may be struggling with the acceptance of the communication deficits, will already be in a difficult place. By having a clinician take the time to build rapport and use appropriate counseling to guide the individual, they are able to help process and begin therapy to compensate for the deficits. Having a clashing relationship between the individual and clinician, may cause the individual to be defensive and refuse therapeutic services.

Psychological Effects of a Stroke

The impact a stroke has on an individual reaches far beyond just a physical and/or communicative impairment. A person's social existence and lifestyle is altered and possibly irreversibly changed which in turn affects their psychological well-being. During hospitalization alone, a stroke survivor will experience psychological stress at a variety of levels (Welch, 2008). For example, if a person suffers from a severe loss of movement due to their stroke, they are required to have a number of medical interventions that causes them to lose their independence. They are now relying on continued care to help assist them in their most basic daily functions such as washing, toileting, and feeding. Consequently, there are numerous emotional and behavioral disorders that occur following a stroke.

One psychological disorder that has been found as the result of a stroke is depression. The Diagnostic and Statistical Manual (DSM) IV categorizes post-stroke depression as "mood disorder due to a general medical condition" with specifiers of (a) depressive features, (b) major depressive-like episodes, (c) manic features, or (d) mixed features (American Psychiatric Association, 1994, p. 211). Major depression occurs in 0-25% of patients that have suffered a stroke and minor depression has been found in 10-30% of patients that have suffered a stroke (Robinson, 1997). There are two studies that have suggested that in spite of the existence of an acute physical illness, post-stroke major depression contains the core features associated with major depression in the absence of a stroke. In the first study, the frequency of depressive symptoms was compared between patients with post-stroke major depression and patients with

"functional" (i.e. no known brain pathology) depression (Lipsey, Spencer, Rabins, & Robinson, 1986). In the second study, patients with post stroke depressed mood were compared with non-depressed patients for the frequency of depressive symptoms. Except for early morning awakening, all psychological and vegetative symptoms of depression occurred more frequently among stroke patients with a depressed mood than among patients without a depressed mood (Fedoroff, Starkstein, Parikh, Price, & Robinson, 1991).

Other psychological conditions that can occur from the result of a stroke are apathy, mania, and pathological emotions. Apathy is the absence or lack of feeling, emotion, interest, or concern and has been reported frequently among patients with brain injury including stroke (Robinson, 1997). While apathy is often co-occurring with depression, manic symptoms following a stroke are much less frequent, however, still prevalent. Patients with mania may show instances of pressured speech, flight ideas, grandiose thoughts, insomnia, hallucinations, and paranoid delusions (Robinson, 1997). Emotional lability is a phenomenon that is characterized by sudden, easily provoked episodes of crying or laughing, which are typically precipitated by seemingly minor stimuli. This disorder is termed pseudobulbar affect when it is associated with bilateral lesions of the cortical projections to the brainstem which can occur during stroke (Robinson, 1997).

Effects on Family Members

An individual suffering from a chronic illness such as a stroke, means that a family member must more frequently take on the role of principal caregiver. The first few days and weeks after a stroke are stressful for families because they are having to deal with the shock of the event as well as anxiety over what the future will hold (Greenwood, Mackenzie, Wilson, & Cloud, 2009). The caregiver of a stroke survivor often experiences an increase in responsibilities and a reorganization of his or her daily life in order to respond to the needs of the stroke survivor, which can lead to a sense of burden (Michallet, Le Dorze, & Tetreault, 2001). Some years ago, Buck (1968) observed that aphasia from stroke was not just a language problem but a "family illness." The same could be said for stroke in general. The spouse of the stroke patient is affected by a number of serious difficulties. Problems encountered by stroke patient's spouses have been characterized as consisting of role changes, shock, guilt, bitterness, depression, loneliness, irritability, an altered social life, and communication difficulties (Christensen & Anderson, 1989).

In a 75-item questionnaire administered to 22 spouses of aphasic patients by Christensen and Anderson (1989), seventy-seven percent of the responses indicated that they "almost always" experienced role changes that involved making medical and financial decisions, assuming dominance in the family, and giving personal care help to the impaired spouse. Thirty-six percent of spouses indicated they had emotional and/or health problems such as losing patience, feeling anxious, feeling irritable and feeling depressed. The results of this study found that stroke with aphasia has a profound

negative impact on the patient's spouse. Role changes clearly represented a major aspect of the adjustment made to their partner's stroke. It is important to note that the spouses in this study indicated that stroke with or without concomitant aphasic complications is emotionally upsetting and engenders feelings of anxiety, irritation, depression, and even a loss of control over the situation (Christensen & Anderson, 1989).

Theories of Counseling Related to Speech-Language Pathology

Humanistic Therapy

Humanistic therapy was developed in the 1940's and 1950's by Carl Rogers (Flasher & Fogle, 2004). This type of therapy emphasizes that people are rational and inclined toward positive growth and self-actualization (realizing one's potential) (Rogers, 1951). Healthy personality development occurs if the person receives sufficient unconditional positive regard. Rogers (1951) states unconditional positive regard is the therapist showing unconditional caring for their clients and positive regard for their inherent worth. He states that "only by showing this consistent and unwavering positive regard can clients feel free to show and to accept themselves." An SLP who employs the humanistic approach will attempt to promote the person's natural positive striving and growth. The clinician's role is nondirective (not trying to influence, being primarily reflective) and supportive while avoiding engaging in confrontation or direct attempts to change the person's behavior (Flasher & Fogle, 2004).

Rogers (1957, p.221) talks about therapeutic conditions that he states are necessary and sufficient for therapeutic change which are:

1. Genuineness: A genuine clinician behaves in a way that is congruent (consistent and genuine) with real feelings and presents himself or herself in an open manner not showing a façade.
2. Empathy: Empathy is a personal encounter, not simply an objective appraisal of the person's problems. It involves "being with" the person and his or her experiences on a moment-to-moment basis. A clinician must understand not only

the clinical condition, but how the condition is affecting the person's self-image and life.

3. Unconditional Positive Regard: A speech-language pathologist accomplishes unconditional positive regard by communicating genuine respect and caring to the person. In doing this, the client is able to experience a non-judgmental environment for what is being asked in therapy, even if the client cannot (or will not) perform the task with maximum involvement or effort.

The humanistic approach places an emphasis on providing a positive relationship rather than on specific therapeutic techniques. The clinician provides reflections that paraphrase the statements or, when needed, point out discrepancies in the communications to help better understand the client's feelings (Flasher & Fogle, 2004).

Interpersonal Therapy

Interpersonal therapy was founded by Harry Stack Sullivan in the 1950's (Gladding, 2000). This type of approach focuses on observable interpersonal interactions, styles of communication, and self-defeating communication patterns (Klerman & Weissman, 1993). According to interpersonal therapy, learned and rigid styles of communication are what cause emotional disorders or disruptions. People do not develop emotional disorders from a single trauma, but from ongoing problems in communication and problematic relationship patterns with important people in their lives (Benjamin, 1993). While it is believed that these roles are learned in childhood, it is not the SLP's job to investigate the person's early childhood history. The SLP should assume that their client's interpersonal patterns were learned early in life and that they

represent the client's best attempts to interact and gain approval of others, and to protect himself or herself from overwhelming anxiety (Wachtel, 1993).

Flasher and Fogle (2004) provide us with some examples of this concept. An adult who is having difficulty making decisions about beginning therapy, continuing therapy, or doing what is asked by the clinician may have had early childhood experiences with parents who were unusually critical of his ideas and decisions. This caused the individual to learn to please his parents by being indecisive and allowing them to make choices for him. Another example stated by Flasher and Fogle (2004) is an individual who shows passive-aggressive behavior toward the clinician. They may smile and nod every time the clinician gives a recommendation or instruction, but the clinician later learns that he has not followed through with any of the recommendations. This person may have also had critical and controlling parents, but his style of coping was to try to develop some autonomy while still appearing compliant. Thus, he developed a pattern of relating by saying one thing to please the listener but without the intention of doing what he says.

These examples show us that as a clinician, one must have the perspective that the client's current interpersonal style is understandable in view of his earlier experiences. This perspective will help SLPs avoid applying derogatory labels to the person (i.e. he's passive-aggressive or she's manipulative). In turn, this will facilitate the SLP to view the person in a positive way and will be empathetic in their interactions with them.

Behavioral Therapy

Behavioral therapy emerged in the 1950's and 1960's and focuses on the universal elementary laws of behavior (i.e. people do what they are reinforced for doing) and place ultimate importance on the role of the environment in creating, modifying, and maintaining particular behaviors (Skinner, 1974). The primary goal of an SLP using this form of therapy is translating symptoms (i.e. anxiety about loss of speech after a stroke) so that they can be understood in terms of concrete behaviors that are observed by the clinician, such as avoiding interaction with friends (Bellack, Hersen, & Kazdin, 1982).

Skinner (1974) contends an individual's behavior develops through a process called operant conditioning. Operant conditioning is a learning process that occurs as a function of its consequences (i.e. rewards or punishments). A behavior that is followed by a reward will increase in frequency. Therefore, clinician's must identify the reinforcers in the environment to understand certain behaviors.

Behavioral therapy tends to be very structured, focusing on techniques rather than simply "being with the person" (Goldfried, 1982). Behavior therapists take an active role in structuring treatment programs to address particular behaviors. This perspective is very consistent with the training received and therapy provided by an SLP. An example of this is a clinician who models appropriate verbal responses to frustration in front of a patient who swears frequently since their stroke (Flasher & Fogle, 2004). If excessive or inappropriate behaviors are occurring, the clinician must focus on changing the consequences associated with the client's response. For example, if the patient is exhibiting negative behaviors (i.e. excessive cursing, yelling, rude commenting) and the

consequence is the clinician ending therapy then the reason the patient may be exhibiting those behaviors is to get out of having to participate in therapy. The individual may have learned that the consequence to these behaviors is escaping therapy therefore they begin to do this every single time. Instead the clinician could use alternative methods for dealing with this behavior such as changing the activity to something that the patient enjoys more or is going to be successful in.

Cognitive Therapy

Unlike behavior therapy that recognizes the role of thoughts in determining behavior, cognitive therapy is founded on the idea that thoughts influence behaviors and people do not just respond to events but to their interpretations and beliefs about events (Beck, 1995). Cognitive therapy recognizes that there are countless perspectives or interpretations of any given event. The way in which people think about their events (their perceptions) determines how they feel about themselves, others, and the future (Beck, 1995). For example, a patient that is discharged from therapy before feeling they have reached their maximum potential may interpret the discharge to mean that they are not worth the clinician's time, the clinician is uncaring, and they will never get better now (Flasher & Fogle, 2004). It is clear that this sequence of thoughts can affect a patient's behavior and mood.

The main goal of cognitive therapy is to help the individual recognize and examine tightly held but problematic beliefs and replace them with more adaptive and flexible ways of thinking (Prochaska & Norcross, 2003). More often than not, an SLP must work with a person's faulty beliefs regarding the communication problem.

Prochaska and Norcross (2003,p.349) list four common types of erroneous thinking or cognitive distortions:

1. Catastrophizing: The person frequently believes the worst will happen, or, if something bad can happen, it will happen to them. An intervention to this may include helping the person see the actual probabilities of the worst happening and focusing on evidence that the worst will not likely happen.
2. "I Should" Statements: These typically reflect perfectionistic tendencies and an intolerance of personal flaws. An intervention to this may include helping the person understand that what he has been able to do easily before the deficit, cannot be done easily now because certain parts of the brain are not working the way they used to.
3. Dichotomous Thinking: The person views events and experiences as one extreme or the other (all good or all bad). An intervention to this may include helping the person view people and experiences on a continuum where even the worst experience or person has some good attributes.
4. Overgeneralizing: The person believes that if something is true in one case, it applies to any case which is similar. An intervention to this may include helping the person understand that his logic may not be accurate and to help the person recognize exceptions to his rule.

Speech-language pathologists using cognitive therapy techniques may vary in how confrontational they choose to be with individuals who are demonstrating these various forms of faulty thinking (Flasher & Fogle, 2004). The common theme is that they do not

take a person's beliefs at face value and instead question them and help them develop more positive and realistic interpretations of experiences.

Family Systems Theory

The family systems theory emerged as a radical alternative to mainstream approaches to clinical psychology and the study of mental illness in individuals in the 1950's and 1960's (Bowen, 1978). This theory emphasizes that a person's emotional problems must be viewed in the context of the family's roles, communications and interactions. Individuals do not have emotional or behavioral symptoms in a vacuum, but rather develop and maintain their symptoms in a dysfunctional family context where there are faulty communication and interaction patterns, and/or faulty family structure (Haley & Hoffman, 1968).

Often times, clinician's interview family members to obtain information about the client, their concerns, and goals for treatment. Potential problems arise when the family member's comments and labels regarding the client bias the clinician's perceptions. The family member's statements may diminish the client's credibility in describing his or her own strengths and weaknesses, which may, in turn, reduce the clinician's perceived need to have an extended dialogue with the client. Family therapy emphasizes concern about the negative labels family members use to describe the client or patient that may bias the clinician (Minuchin, 1978). Clinician's must be aware of how labels may be used to control a family member's behavior because assigning a label gives one family member power over another.

Speech-language pathologist's working from the family therapy perspective come to the realization that they are unable to remain the neutral outsider when working with families. Family members tend to compete for an alliance with the clinician, and certain family members may try to monopolize the therapy time (Flasher & Fogle, 2004). This causes the clinician to inevitably become part of the family system. A clinician will try and use this role carefully by deciding when to "join" with a particular family member in order to gain compliance with a medical recommendation or to encourage the client to assume increased responsibility for self-care during therapy. Speech-language pathologists can look at the communication roles, and meanings of life experiences that families develop to try and achieve balance and coherence (Flasher & Fogle, 2004). Interventions that are incorporating this theoretical approach focus on trying to get families to interact and communicate in healthier ways with one another.

Existential Therapy

Existential therapy focuses on the ultimate conditions of life and how people deal with tragedies of existence (Corey, 2001). People face conditions of existence that are profound (i.e. we grow up, we grow old, we become ill, we die). Yet knowing these conditions, we still strive to be good children, good adults, good workers, and good to our neighbors (Yalom, 1980). Somehow people still strive to find meaning to pursue their goals and to be responsible despite the inevitability of their own demise.

Speech-language pathologists inevitably encounter existential issues in their work (i.e. when a clinician is working with an adult patient who is struggling with his cognitive losses and the meaning of life after a stroke) (Flasher & Fogle, 2004). Yalom (1980,

p.273) describes some of the specific concepts considered by existential therapists that are relevant to clinicians:

1. Existential Uncertainty: Existential uncertainty involves the fact that as much as we attempt to control events in our lives, we discover that many events are outside our control. The belief that that one should be able to eliminate uncertainty can leave one feeling guilty when unable to control tragic events, especially for those loved ones.
2. Existential Meaninglessness: Existential meaninglessness refers to anxieties about the meanings created for oneself that may be obliterated by a single event. Tragedies such as an adult suffering a severe stroke, may lead to the terrifying thought that there is no meaning, no significance in existence. The challenge is to find meaning in life despite the adversities in order to endure life on a daily basis.
3. Existential Isolation: This is the feeling of ultimate aloneness in the world. Existential isolation refers to the unbridgeable gulf between any other person and ourselves. This feeling is often experienced by elderly people in convalescent hospitals that have lost most of their family and close friends. However, speech-language pathologists need to be aware that non-hospitalized people may be experiencing a profound sense of isolation in the midst of their illness and suffering, even when surrounded by loving family and friends.
4. Existential Nonbeing (Death): Although death arguably is the single most important issue of life, it is a topic that most people avoid. The experience of the inevitability of our end, of our death, is referred to as the realm of nonbeing. This

> motivates many people to turn to diversions in life, a lust for lasting fame, and reckless activity which seem to defy the possibility of death (i.e. race-car driving or extreme sports). The reality is that patients and their families likely think about death much more than might be imagined. Given the slightest encouragement, patients will often discuss their concerns about death.

Speech-language pathologists will use these concepts to gain an understanding on each patient's unique experience of being-in-the-world (Boss, 1963). They will focus on how people perceive themselves and their surroundings, and how they manage to create meaning in their lives.

Multicultural Theory

The development of multicultural theory began in the 1960's when there was an increase of cultural diversity in the United States, particularly in African-American, Hispanic, Asian, and middle Eastern populations (Prochaska & Norcross, 2003). This theory emphasizes that the culture of both the clients and their families as well as the cultures of the clinicians influence the counseling process both pervasively and profoundly (Flasher & Fogle, 2004). While much of the recent speech-language pathology literature on multicultural populations focuses on children and the demands for services in the public schools, it is important to remember that many adult clients and their families have diverse cultural backgrounds as well.

Multicultural theory emphasizes the importance of taking into account culturally diverse world views and being aware of our own cultural, racial, and ethnic backgrounds and how they influence us. Clinicians must be very aware of the influences of larger

cultural and ethnic backgrounds and the subcultures they have been a part of, and how they affect interactions with patients and their families as well as other professionals. Shipley (1997, p.133) discusses numerous assumptions and values of Americans with mainstream backgrounds that may differ significantly from other cultures such as:

1. "Punctuality is important and is an intrinsic part of a professional relationship based on mutual respect."
2. "In professional situations such as meetings, it is important to 'get down to business' as quickly and efficiently as possible."
3. "Informality and social equality are the ultimate goals in all interactions between professionals and clients."
4. "Frankness, openness, and honest discussion of situations and feelings is important."
5. "The gender of the clinician and the client is not important; the clinician's competence is the most important variable."
6. "The age of a clinician, relative to the client, is unimportant as long as the clinician is competent."
7. "Written documentation is a necessary and intrinsic part of professionals' interactions with clients and families."
8. "Speech and language therapy are usually necessary even if the client does not have an overt physical handicap."
9. "Rehabilitation is usually necessary because the goal for all individuals, including those with speech and language impairments, is to be as independent as possible."

10. “When clients display speech-language disabilities, Western forms of intervention are the most effective and appropriate.”
11. “When a particular client is receiving rehabilitative services or therapy, the family must be as active as possible in collaboration with the clinician.”
12. “Individuals have control over their own destinies.”
13. “Families who speak other languages at home need to speak English to their children so that the children will learn English.”
14. “Counseling individuals in isolation can be quite effective.”

These assumptions are often such a basic part of the way we think about the world and interacting with people that it may not occur to us that other people may make different assumptions (Flasher & Fogle, 2004). A clinician must be careful not to elevate these values or consider them ideals because that may lead to negatively judging people who have different or opposing values. There is no one multicultural perspective or approach that is appropriate for working with all cultures and it is impossible for any clinician to be so well-educated that they understand the numerous cultures and subcultures within his or her community. Battle (2002, p.251) presents helpful “dos” and “don’ts” when considering a person’s cultural background:

1. Consider your own personal cultural beliefs, attitudes, and values and how they may be contributing to the clinical encounter.
2. Learn the name of the person’s cultural or geographic group that is commonly used by that group.

3. Avoid using questionable negative connotations such as culturally deprived, culturally disadvantaged, or minority.
4. Do not overgeneralize or stereotype individuals or groups of individuals.
5. Be aware of the nonverbal sources of miscommunication between people from different cultural groups, such as styles of greeting behavior, the role of touch during conversation, and appropriate topics of conversation.

Culturally sensitive clinicians clearly have multiple responsibilities. One is to learn about cultural diversity (Kuo & Hu, 2002). Clinicians cannot possibly learn all the values and customs of all societies of the world, however, they can learn about common beliefs and values held by people belonging to the major ethnic groups in their communities. Another responsibility a clinician has is to provide services without any personal bias. There are many times where one's personal beliefs do not align with another's, however, this should not prohibit the individual from receiving services. It is the clinician's job to look passed that and find alternative ways to help the individual. Also, as SLP's we must be careful to not generalize or stereotype. It is important to address an individual with a clean slate and not have any prior misconceptions when beginning any services. It is the SLP's responsibility to look at each case individually without comparing the person to any previous patients or general misconceptions they may have.

Integration of Theories

There are many prominent theorists that have attempted to integrate or combine elements from various theories (Safran & Segal, 1990). An SLP may use a variety of theoretical concepts to interact with a client and their family. Because SLPs work with a

variety of disorders for individuals of all ages, it's important that they draw upon concepts, strategies, and techniques from a variety of counseling frameworks to communicate effectively with clients and their families (Flasher & Fogle, 2004). An integrative approach to using counseling techniques strives to look beyond the constraints of single-theory approaches to see what can be learned from and how clients can benefit from other perspectives (Corey, 2001). Patterson (1986, p.93) cites seven commonalities among counseling approaches:

1. The counseling approaches agree that humans can change or be changed.
2. The approaches agree that some behaviors are undesirable, inadequate, or harmful, or result in dissatisfaction, unhappiness, or limitations that warrant change.
3. Counselors expect people to change a s a result of their particular techniques and interventions.
4. Individuals who seek counseling experience a need for help.
5. Clients generally believe change can and will occur.
6. Counselors expect clients to be active participants.
7. Intervention characteristically includes encouragement, support, and instruction.

Clinicians may find that being open to an integrative perspective will demonstrate that multiple theories play a crucial role in their personal counseling approach. There is no one theory or technique that is going to always be effective when working with a wide range of ages and disorders.

Key Components for Effective Counseling

Transference and Countertransference

A client's feelings, expectations, perceptions and attitudes are referred to as transference, while the clinician's feelings, expectations, perceptions and attitudes are referred to as countertransference (Flasher & Fogle, 2004). Since these experiences are inevitable, it is wise for clinicians to understand these forces that can exert a powerful influence over the therapeutic climate.

Transference refers to the past experiences that have shaped how we perceive new situations and people (Flasher & Fogle, 2004). A person's transferences can be thought of as organizing principles that help filter, organize, and attend to certain characteristics or behaviors in other people (Kahn, 1999). By becoming more attune to the transference phenomena, clinicians can make sense of situations and avoid defensive counter moves when clients behave in puzzling or irritating ways.

The counterpart to transference is countertransference. This concept refers to the clinician's personal psychological "baggage" which interferes with therapy (Flasher & Fogle, 2004). Interpersonal theorists Anchin and Kiesler (1982) state that countertransference responses should not be concealed or eliminated because they can be used as a tool to understand clients better. The clinician's countertransference response may provide important clues about what the client is feeling or thinking about the clinician. Clients are often responding to how the clinician has treated them or what they perceive the clinician has communicated to them. The goal for a clinician is to become

comfortable and non-defensive about their own emotional responses so that they can reflect on what factors triggered them.

Attending and Listening

A foundational and prerequisite element of a therapeutic relationship is attending to the client through both auditory and visual channels (Flasher & Fogle, 2004). Barkley (1998) says that attending (attention) includes arousal (being alert), selective attention (choosing what to attend to), sustained attention (staying focused), and how much information can be attended to or processed at one time. Clinicians must first attend to their clients before they can listen to them. Many times, a client will be speaking to the clinician while the clinician is attending to something else. Flasher and Fogle (2004, p.94-95) state seven obstacles to attending and listening to clients:

1. The clinician's stress and anxiety.
2. Negative value judgments of the client.
3. The clinician is so eager to respond that he or she listens only partially to what the client is saying.
4. Rehearsals of what the clinician is planning to say.
5. Problems the client is presenting are very similar to problems the clinician is personally trying to manage, resulting in splitting the clinician's attention between the client's problems and his or her own problems.
6. The client's experiences are very different from the clinician's and the clinician is having difficulty relating to the client.

7. The clinician not feeling well or being preoccupied by his or her own physiological needs such as hunger.

Although listening to clients and family members may take more time in the short-run, it may also save time in the long run. Careful listening can lead to a modification of therapy plans that better meet the client's needs and preferences. By doing this, the clinician is then able to focus the therapy on what is driving the client's motivation.

Tone of Voice

Tone of voice communicates an immense amount of information and can be even more powerful than the content of the message. Throughout the life span, the sound of a person's voice often mirrors the person's emotional state (Boone & McFarlane, 2000). From the perspective of a client and family members, a clinician's voice may affect how they perceive and react to therapy. For example, if the clinician is using a tone of voice that is friendly and warm yet still authoritative, this may elicit fondness and respect from the client and family members. However, a tone of voice that sounds belittling or critical may discourage clients and family members from returning to therapy.

Empathy

Empathy is the cornerstone to all therapeutic interactions and the principal route to understanding clients and their families and helping them feel understood. Important skills for empathic understanding include attending, listening, paraphrasing, reflection of feeling, and summarizing (Flasher & Fogle, 2004). In a way, the clinician is allowing himself or herself to feel the client's distress or emotional suffering and what it might be

like to go through that experience (Brammer & MacDonald, 1999). Ivey (1998, p.109) states a 1-2-3 pattern for providing an empathetic response:

1. The clinician attends to, listens to, and observes the client's verbal and nonverbal behaviors. The clinician selects thought or feeling the client has communicated, and paraphrase, reflects, or summarizes the thought or feeling to the client.
2. The client responds to the clinician's statement (observation) with verbal and nonverbal behaviors. The client's response may indicate general agreement or disagreement with the clinician's remark.
3. The clinician again attends to, listens to, and observes the client's verbal and nonverbal behaviors and responds to the client's behaviors.

These empathetic responses are important to communicate effectively as the clinician is often sharing a diagnosis with a patient or family member. They often involve the use of non-blaming language so that the client or family member can feel that whatever they have done, or whatever they are thinking or feeling is normal.

Respect for the Person

A clinician's questions, suggestions and interventions should always convey respect for individuals and should affirm that they are doing the best they can under difficult circumstances (Flasher & Fogle, 2004). Linehan and Kehrer (1993) explain that there is a very delicate balance between acceptance of individuals for who they are (and how they feel at the moment) and encouragement to change. Respect for the person is most often communicated through daily interactions rather than through direct

statements. The clinician's behaviors convey an implicit respect for the person's dignity, privacy, autonomy, and vulnerability (Flasher & Fogle, 2004).

Conclusion

The psychological impact on an individual that has suffered a stroke can be profound and life altering. Serious mental health issues can arise from a life altering event such as a stroke. Common psychological effects that have been observed in individuals that have suffered a stroke are depression, anxiety, apathy, and mania. A stroke not only affects the individual themselves, but their families and caregivers as well. Spouses may feel a tremendous stress in the role changes that might occur due to their loved one being unable to maintain their primary role in the family.

There are many psychological theories that SLPs can apply towards their practice. Most of the theories discussed involve analysis of culturally influence behavior, family functioning, existential concepts, and values development. There is not one theory or approach that is going to fit every individual given the diverse caseloads many SLPs have. The foundation of counseling is in the clinician-client relationship. That being said, SLPs should work on placing an emphasis on connecting with the client and their family.

Counseling involves components which the SLP can easily put into practice to help build their therapeutic relationship. Using these components will enhance the potential effects of the treatment being provided. Understanding and being attentive to transference and countertransference experiences can give clinicians the tools with which to better manage therapeutic relationships. The foundation to this relationship is the ability to listen and attend to the client. The challenge many SLPs face is conveying

acceptance of the person and still encouraging change. Empathy plays a central role in helping to do this as well as the tone of voice a clinician uses.

The goal of providing counseling support is to help families grieve and come to terms with the reality of their situation. From there, SLPs can help families develop coping strategies and identify adaptations that can be made to help both the caregiver and the patient live as fully as possible. Interventions that provide psychological support can have a positive impact on the emotional health of caregivers. While SLPs bring expertise in specific clinical areas to the evaluation and management of communication disorders, they must develop the important skill of effective counseling of clients and families to support decisions and behaviors that optimize quality of life. Appropriate counseling greatly increases the opportunity of an optimal outcome for clients, whether this involves resolving a specific disorder or maximizing quality of life by means of coping and adjustment techniques.

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